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Tough PSRO sanctions in the works — but may never be used

WASHINGTON, D.C.--BQA* staff members are working to develop a set of tough sanctions that few want and most believe will rarely, if ever, be used.

Why are they doing it?

Because the PSRO law says they must.

It's that simple, Dr. William B. Munier, acting director of OPSR, told the July meeting of the National Professional Standards Review Council. "In the opinion of the general counsel and the Secretary, we will not be in compliance with the law if we do not have such regulations."

NO ROOM TO MOVE

"The PSRO program is very complicated," Dr. Munier said, "but I think that's one of the things that's fairly clear. There just isn't much room to move in it."

However, he added, "I certainly hope the sanctions won't need to be used very often, and I don't think they will be." According to a BQA position paper prepared for the July meeting, Congress felt that "past Medicare and Medicaid experience indicated the need for stronger measures that could be applied when educational efforts and repeated denial of payment failed to cor-

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INSIDE STORIES:

Hospitals left in quandary over UR implementation as injunction is upheld

With a federal appellate court upholding the May 27 preliminary injunction against the July implementation of utilization-review regulations, hospitals have been left in a quandary over whether they should be developing contingency plans for compliance with the enjoined sections.

EARLY TRIAL SOUGHT

The 10-page decision supporting the injunction was issued July 23, and the case will now return to the original district court for trial on its merits. The government has requested an early trial date and expects the case to be heard by late August or early September, according to Patricia Q. Schoeni, associate administrator for communications and public affairs, Health Services Administration.

Ruling on a suit filed Feb. 20 by the American Medical Association against the Secretary of DHEW, U.S. District Court Judge Julius J. Hoffman granted a preliminary injunction, enjoining DHEW from enforcing the UR regulations July 1.

DHEW's resulting application for a stay of the injunction was denied June 30 by the U.S. Court of Appeals for the Seventh District.

In light of the court's denial of a stay, DHEW--still optimistic about the outcome of its appeal--published in the July 3 Federal Register an extension of the deadline for hospital compliance with the enjoined portions of the UR regulations [Sec-

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*BQA--Bureau of Quality Assurance

Hospitals left in quandary over UR implementation as injunction is upheld

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tions 405.1035 (e) and (f)].

The new date for compliance was set for July 30, several days after the projected time for a decision on the government's appeal of Hoffman's ruling.

As of July 30, one week after the injunction was upheld, DHEW had issued no written directives to hospitals on developing contingency plans for compliance with the enjoined sections, according to Gaylen Newmark, staff associate of the American Hospital Association's Bureau of Professional Services.

DIRECTIVES VARY

Verbal directives from regional offices on preparation for compliance are varying widely, Newmark said.

At the moot deadline, government officials were meeting with the general counsel to plan their next step.

Schoeni of the HSA said that within a few days of that deadline, DHEW would probably publish an official notice in the Federal Register, which will say the government will enforce all parts of the regulations except the enjoined sections.

The BHI*, Schoeni said, has notified hospitals that validation surveys will be conducted in accordance with the revised plans that 90 to 95 per cent of the nation's hospitals have already submitted.

The next court term is scheduled to begin in October, according to Donald P. Wilcox, assistant director of the Health Law Department in the Office of the General Counsel for the American Medical Association. Judge Hoffman, in whose court the case will be tried, sets the date and, in response to the government's request, can assign a date earlier than the October session, based on his judgment of the urgency of the case, Wilcox said.

"Of course we (the AMA) expect to win the case--otherwise we wouldn't have filed the suit," Wilcox said. He pointed out that the government also has the options to withdraw the regulations or to amend them. At press time, neither withdrawal nor further amendment of the regulations (beyond the published extension of the compliance deadline for rural hospitals) was under consideration, Schoeni said.■

Tough PSRO sanctions in the works — but may never be used

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rect inappropriate professional behavior."

Therefore, section 1160 of the PSRO law gives the Secretary authority to fine or exclude practitioners permanently from reimbursement and to fine or terminate providers permanently from reimbursement under the Medicare, Medicaid, Maternal and Child Health, and Crippled Children Service programs. The issue paper pointed out that sanctions were essentially a "last resort" approach, but even so, several council members questioned seriously the need for sanctions.

MAY BE A MISTAKE

Noting that the Utah PSRO had experienced no difficulty in dealing with such problems, Dr. Alan R. Nelson of Salt Lake City said, "We are going to have problems with this until we find out whether there is any imperfection. It may be a mistake.

"Let's put it in abeyance until we find that there is a need for sanctions, and in what area."

Fellow council member Dr. Donald Harrington of Stockton, Calif. agreed, noting that while sanctions may need to be developed, "spelling them out in too much detail is going to create more problems than it solves."

BQA director Dr. Michael J. Goran noted that because of the law, "We can't put it aside."

"Regulations are needed to shape policies that will be reshaped by experience," Dr. Goran said.

ANTICIPATING NEEDS

Nelson said BQA was "trying to anticipate our needs. I think you should wait until we identify those needs."

In a comment to PSRO Update after the meeting, Dr. Munier said that if Dr. Nelson were right about the lack of need for sanctions, then whatever mechanism is developed probably will not need to be used very much.

"I don't think that because we make regulations, people are going to start sanctioning," he said.

BQA is working to prepare proposed regulations within about six months. However, in view of the attitude of the council members, BQA may elect to take the advice of council member Dr. Willard C. Scrivner of Bellville, Ill., and "make haste slowly."■

*BHI--Bureau of Health Insurance

Progress Notes from the Northeast

P/S/R/O Update New England & New York

New York

Most of the PSROs in New York State are concentrating on hospital delegation, while the troublesome question of reimbursement for the special staffing of UR* committees remains unclarified.

One area, the Five-County Organization for Medical Care & PSRO, N. Hartford, faces a situation in which some of its 13 hospitals, specifically the smaller hospitals, would prefer the PSRO to handle UR rather than be delegated themselves. "Some hospitals want to be delegated, some want to be delegated in part and some want the PSRO to handle the whole job," Russell Feltus, managing director, said. "It makes for a somewhat complicated mechanism."

A spokesperson for the Bronx Medical Services Foundation pointed out that the problem is that "most hospitals need front-end money to hire review coordinators." He said that the PSRO had reviewed seven hospitals, that three "will go on line in September and be responsible for admission certification, continued-stay review, and medical-care-evaluation studies." He added, "We are organizing a seminar for review coordinators," and said that a review coordinator had been hired to work on the PSRO staff, and will also work at the three hospitals (Montefiore, Union, and the Hospital of the Albert Einstein College of Medicine).

The Bronx PSRO has begun negotiation to develop a memorandum of understanding with the Blue Cross of Greater New York, Travelers Insurance Co., and the Bureau of Health Insurance (intermediaries for the Health and Hospital Corporation of New York). "Basically, the memorandum will indicate who's responsible for what activities, as well as outline communications," the spokesperson said. "It also indicates what information needs to be forwarded to which party."

From Rochester, Jack Coleman, executive director, Genesee Region PSRO, reported that his group will start reviewing plans on delegation in September of five of the 21 hospitals covered, and will phase in the remainder in six months. Coleman said that the question of reimbursement for staffing the UR committees had not been thrashed out. In the memo of understanding with the intermediaries (Blue Cross, the State Health Department, etc.) he said, "We can't get them to agree on the precise amount, and they say they can't state the amount until they get guidelines from DHEW."

While looking ahead to the eventual operation of the statewide data bank, the Area 9 PSRO of New York State Inc., Purchase, is planning an arrangement with a private company, Dikewood Corp., to do a certain number of data abstracts for a one-year period, according to Michael Maffucci, executive director.

Dikewood has done such work elsewhere, Maffucci noted. Its abstract would cover length of stay, diagnosis, approvals and so forth, and "would give us enough of this to provide the management type of service we'd need," Maffucci said. He said his PSRO also has a contract with the Dikewood firm to help develop a procedure manual and training material, which is nearly completed.

Meanwhile, Maffucci said his PSRO has arranged preliminary meetings with six of the 17 hospitals to review their plans for UR.

The Professional Standards Review Organization of Rockland has been meeting with administrators of Good Samaritan, Ramapo and Nyack Hospitals to determine their view on delegation. Meanwhile, two subcommittees have been established, one to consider utilization review for long-term-care facilities, and the other to form advisory groups to PSROs, according to Jack Cohen, executive director.

The Nassau Physicians Review Organization, Garden City, has concluded initial evaluation of delegation plans for 16 hospitals, according to Eugene O'Reilly, project director. The PSRO recently held a two-day institute for UR, attended by 62 individuals from 36 hospitals in the Greater New York area. O'Reilly said that Dr. George Himler, past president of the Medical Society of the State of New York, has been appointed medical director of the Nassau PSRO.

Sheryl Buchholtz, associate executive director, Kings County Health Care Review Organization, Brooklyn, reported that her group is working on several pamphlets for hospitals to use in utilization review. ■

*UR--Utilization Review

Data system consortium taking shape in N.Y. State

With general agreement among the various groups concerned, steps are now being taken to form a statewide hospital-patient data system in New York State.

There was some fear on the part of PSROs that they might not be adequately represented in such a consortium, but it was informally agreed after several meetings that, at this time, the PSROs would join on the basis of having at least 40 per cent representation on the consortium board.

The first steps include formal incorporation of the system with the state and preparation of a draft application for a DHEW grant. Those participating include the PSROs, the Blue Cross Association, the Hospital Association, the Hospital of New York State, the Association of Private Hospitals and commercial insurers.

BASIC AGREEMENT

"There was basic agreement, at least on the first step, on what the consortium would be and how representation would be incorporated," Dr. James D. Wharton, assistant commissioner for medical services and evaluation, New York State Health Department, told PSRO Update. "I think it's premature to say just what the consortium will be, but everyone agrees on the objectives: that is, to arrange things so that hospitals will submit one abstract to satisfy all purposes. The purpose of the consortium will be to provide to all participants the data they will require."

The data would be based on the uniform hospital discharge data abstract, or the modification of that for the PSROs, Dr. Wharton said. "Clearly, when we're speaking of a uniform data system, we're not talking about specific individual hospital-inquiry type of things, which may require special additional sets of data," he said. "I think the system would use the nationally specified sets of data."

Spelling out his understanding of the system, Wharton said, "I would not think an individual Blue Cross organization, for example, would be entitled to patient identification, physician identification and the like on other than Blue Cross patients. They would be entitled to overall statistical information for comparative purposes. I would think the same Blue Cross, if it were a fiscal intermediary, would be entitled to specific patient identification, physician identification, etc., on both its own contract patients and fiscal intermediary patients, but not to such information on patients paid for by, say, Mutual of Omaha."

ECONOMIES CITED

Dr. Wharton said the state will offer to the consortium the use of the state's "NYSHUR" system, which now collects "nearly all the information that the consortium would want to collect on Medicaid patients." He saw the consortium as offering "tremendous economy" in respect to data operations and economy of scale.

Dr. Peter Rogatz, executive vice president, Blue Cross of Greater New York, welcomed the statewide data-system plan as "extremely sensible," and said he believed it would be extremely valuable to the PSROs.

"At present we have our own claim forms, which contain enough data to establish a fairly good analysis of experience by hospitals in our 17-county area," he said. "We anticipate the establishment of criteria to be more of a PSRO function. I think the PSROs and Blue Cross have a great deal in common. I think the PSROs are interested in the quality of care and cost control, and so are we."

John Garrison, vice president for operations, Hospital Association of New York State, hailed the statewide data consortium as having "a great deal of potential," and said, "We are working with other parties to try to get it actually operating."

BOARD COMPOSITION

The single big issue has been the composition of the board of directors of the consortium, Garrison said. At present, there are four major blocs--the providers (the hospitals), the third-party payers (Blue Cross, commercial insurers), the PSROs and the state health department people. Garrison's association represents 300 nonprofit voluntary hospitals throughout the state.

A spot check of the PSROs showed that some are going along with the move to form a statewide data bank with reservations. While acknowledging that the consortium had value, various PSROs felt, for example, that they could be outvoted in the consortium's board of directors.

Jack Coleman, executive director of the Genesee Region PSRO Inc., Rochester, expressed this view: "In principle, we agree, but there are a lot of problems that have not been addressed or solved yet. None of

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Statewide PSR Councils, with appellate power on PSRO decision, coming soon

Statewide PSR councils with appellate power over PSRO decisions, are due to be created soon in the three largest states of the Northeast -- Massachusetts, Connecticut and New York.

P.L. 92-603 (the PSRO law) required that statewide councils be established after three PSROs in a state have become conditional, and, although the law sets no time limit, BQA is anxious to have members appointed this fall.

A NEUTRAL APPROACH

"Our approach is to be as neutral as possible in developing statewide councils," said BQA staff person Dorothy Moga in her report to the National Council last month, "especially in view of their authority in the areas of appeals and sanctions. Also, we're beginning to get inquiries from support centers and PSROs."

The major responsibilities of the councils are: to hear appeals from practitioners of decisions made by PSROs; to review sanctions reports as they are routed to the Secretary; to assist the Secretary in evaluating PSROs; and to help coordinate PSRO activities in the state and disseminate information among them.

Some rough spots are expected because statewide councils are mandated to assume some of the functions (notably coordination) which the state support centers have been carrying out; the latter were created as a convenient administrative mechanism and are not a requirement of the legislation.

Both Massachusetts and Connecticut support centers have said they anticipate providing staff support to the councils, a possibility, according to BQA, through a subcontract for services.

NOMINATION REQUEST

Sometime soon, the Secretary will request nominations of members for the statewide councils from the appropriate sources; the members will be: one representative from each PSRO; four physicians (two recommended by the state medical society, two by the state hospital association); and four public members knowledgeable in health (two of whom are recommended by the governor).

For the public members, the government will solicit nominations through a public notice in the Federal Register at the time the secretary requests the categorical nominations.

BQA is now at work on articles of incorporation, model bylaws, details of staff support and a model agreement or contract for funding.■

New England

Now that contracts have been completed for this fiscal year, the highest priority for New England conditional PSROs is to work out data requirements, select data systems and begin utilization review.

The four Connecticut PSROs have been meeting with CMI*, the support center, which is writing specifications for a data system; all PSROs would like to have a single statewide system, but discussions in the next few weeks should determine whether that's feasible. Two data systems are under strong consideration, but more than a dozen have been examined.

GOING TO REVIEW

Massachusetts PSROs are at various stages of settling the question of data systems. Charles River, one of the "old" conditionals, has chosen an adaptation of the UIS* form and system used by the Massachusetts Hospital Association. It will begin review in one of its eight hospitals the first week of this month.

Bay State, one of the first conditional PSROs, will try out its own data form in a field test of four large hospitals for two to three months. Putting a data system into operation may take up to six or seven months; the process includes going to bid or receiving a waiver, selecting a data firm and designing a program.

Western Massachusetts and SEMPRO, the state's new conditionals, are still evaluating their needs for a data system; Central Massachusetts remains a planning PSRO with funding through October. Thus, the Massachusetts PSROs are pursuing independent directions on the data questions.

Pine Tree PSRO in Maine is waiting for some clarification from Washington on the role of intermediaries in data processing before proceeding with its original plan to use PAS* and the Maine Health Data Services, and have the Cooperative Health Information Center in Vermont merge the two abstracts.

New Hampshire and Rhode Island PSROs continue to look at their data needs. Vermont, which is still a planning PSRO, has not come close enough to review to have begun to resolve data questions.■

*CMI--Connecticut Medical Institute
*UIS--Utilization Information System
*PAS--Professional Activity Study

Government moves in response to PSRO field criticism

Evidence that the government is responding to criticism of the PSRO program from the field (especially New England) was disclosed at the July National PSR Council meeting in the announcement that BQA is looking at the question of flexibility and may respond by changing from a contracts mechanism to an agreements mechanism for funding.

This was the word from Dr. William Munier, acting director of OPSR, who cautioned, however, that a change in mode of funding would have to be balanced with accountability in using public funds.

He spoke also of looking at alternative methods of physician reimbursement, in light of the criticism evoked by the $35-per-hour limit.

Carrying this responsiveness further, Dr. Michael J. Goran, director of BQA, told the National Council that his agency was moving to change the procedure for transmittals to elicit comment before freezing policy into official form.

SLOTTING REVISION

As a case in point, he noted that the policy on slotting has been revised, and will be defined in a coming transmittal, of which there will be a preliminary form prior to official issuance.

Slotting refers to the need felt by some PSROs to reserve places on the board of directors to certain categories of physicians and osteopaths. Heretofore, the government has mandated completely open membership on the PSRO board of directors. The change in this stance came about particularly through the efforts of the AAPSRO*, according to Stephen Epstein, general counsel for the organization.■

Medical-care coordinators plan September election

In addition to the New England organizations of review coordinators mentioned in last month's PSRO Update, there is the National Association of Medical Care Coordinators, incorporated by the CIM* in Boston in the summer of 1974.

The organization now has draft bylaws and expects to hold elections for officers in September.

Members, who pay annual dues of $35, come from Massachusetts, New York, New Hampshire, Washington, D.C., and Virginia, CIM reports, and have been drawn from the ranks of the CHAMP* coordinators and those who have taken CIM's training courses. A qualifying examination determines eligibility for membership.

In the early stages of organization last year, an attempt was made to link MURA* with this CIM offshoot, but discussion broke down and the two groups proceeded toward incorporation independently. Eligibility for active membership in MURA requires that a coordinator be hospital-based, a provision which eliminates CHAMP coordinators, who are employed by the statewide monitoring system, not by the hospitals. They can, however, be affiliated members of MURA.

Different objectives distinguish CHAMP coordinators from hospital-based coordinators: the former monitor hospital costs for Massachusetts Medicaid patients, the latter monitor quality of care within the hospital, eventually for all patients.■

Medical profession's PSRO responsibility theme of S.F. meeting

The combined annual meeting of AAPSRO and AAFMC* in San Francisco Aug. 9-13 will have as one of its major themes the medical profession's responsibility to PSROs.

'GRASS ROOTS' TO TALK

Several staff members of the BQA will lead a workshop on PSRO data. "The Grass Roots Talking" will be the title of a panel moderated by James Byrne, M.D., president of the Dade/Monroe FMC, and including among its members John Bussman, M.D., president of the AAPSRO; Gerald Besson, M.D., chancellor of IPS*; Michael Goran, M.D., director of the BQA; Stephen Epstein, general counsel for AAPSRO; and Walter Wood, president of Dikewood Corp.

Dr. Goran will also address the AAPSRO business session on Sunday, Aug. 10. New England members will be hosts at a reception Sunday evening.

Topics of other talks and panels will include the art of negotiations, PSRO and quality assurance, and the legal aspects of quality assurance. Workshops will be devoted to the role of the medical director and the physician adviser, the executive's role as financial manager, hospital delegation and monitoring, and medical-care evaluation studies.■

*AAPSRO--American Association of Professional Standards Review Organizations
*CIM--Commonwealth Institute of Medicine
*CHAMP--Commonwealth Hospital Admissions Monitoring Program
*MURA--Massachusetts Utilization Review Association
*AAFMC--American Association of Foundations for Medical Care
*IPS--Institute for Professional Standards

Medical audit: The hub of good UR

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central to UR, the entire evaluation of the physicians and the providers and the institutions is handled in one committee; the evaluation of different components of medical care is, therefore, not fragmented. That means that the one committee or one group of physicians is looking at the patient patterns as a whole, and not looking at individual parts of the patient's stay in the hospital.

The role that the administration plays in this whole system is very critical because it must provide the nurse coordinator as well as record-room personnel in order to perform both medical audit and UR simultaneously.

However, another key point of the implementation of effective UR is that the salaried people the administration must pay for have to be directly responsible to the medical staff through the UR chairman. And this is the best form of internally-delegated UR--where the UR coordinators are responsible administratively to the medical staff. This is a concept that has only recently been accepted by most hospitals.

PUTTING SYSTEM TO WORK

In time, by using medical audit as the criteria-generating source for utilization-review activity, the primary purpose of the UR system will be to affect those areas where quality review must be concurrent. For example, if it is noticed that 20 per cent of patients are going to surgery without a prior chest X-ray, when the medical staff feels that all such patients should have chest X-rays, then someone should be made responsible to review all pre-op patients for the presence of a chest X-ray. This to me, would be a better use of the UR system than exclusively looking at the cost-containment measures. And in time, the medical staff, using medical audit to identify problems retrospectively, could use the concurrent review system to implement other areas where concurrent quality monitoring may become necessary.■

Alan C. Brewster, M.D.

Data system consortium taking shape in N.Y. State

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the hairy problems have been addressed. Once the data is collected, for example, maybe the Blues will say, 'We won't give you what we collect.'"

Support for the idea was given by Michael Maffucci, executive director, Area 9 PSRO of New York State, Inc., who said, "I think it will be great for everyone," and added, "I'm sure none of the hospitals, PSROs and private insurers really want to control the data center." Maffucci foresaw expanding use for the data bank, such as serving ambulatory patients as well as in-patients.

GOING ALONG

Russell H. Feltus, managing director, Five-County Organization for Medical Care & PSRO, N. Hartford, said that his board of directors had approved the voting of the PSROs to "go along with the consortium" on the basis of a 40 per cent representation, and on the basis that if an individual PSRO area goes conditional, it, too, would have a vote.

Some aspects of the consortium "make me nervous," said Eugene O'Reilly, project director, Nassau Physicians Review Organization, Garden City. "We're going to go along with everyone else on the 40 per cent representation in the present planning stage, but we're not committed yet to the whole idea," he said.

O'Reilly added that among the "things we don't like is the fact that the state has the authority to exercise a certain amount of power and influence over members (excluding the PSROs) of the consortium." In his view, the state "can exercise control of 60 per cent of the vote."■

Support centers on last year of direct federal funding

Beginning next July 1, PSRO support centers, in order to remain in business, will have to receive their funding from the PSROs in their states. Effective at that time will be the end of the federal policy of awarding contracts directly to the support centers, to supplement funds they receive from their state PSROs.

For the current fiscal year, the following amounts have been awarded to the support centers in the northeast:

--Massachusetts (Commonwealth Institute of Medicine): $149,975
--Connecticut (Conn. Medical Institute): $149,651
--New York (Medical Society of the State of N.Y.): $137,606■

OPINION
Medical audit: the hub of good utilization review

The author is chairman of the staff medical audit committee and director of gastroenterology at St. Vincent's Hospital, Worcester, Mass. He is also an assistant professor of medicine at the University of Massachusetts Medical School.--Editor

Most utilization review programs have emphasized cost containment over quality of care. As a result, physicians, who are concerned with the quality of care, show very little enthusiasm or interest in programs that are designed to control cost. What I'd like to emphasize is the use of medical audit--as a prerequisite of any good utilization review plan--in order to involve physicians in the quality aspects of medicine, and only indirectly in the cost-containment components of it.

By use of medical audit in utilization review, I'm referring to the retrospective evaluation of patterns of patient care, of problem areas in utilization of services and of quality of services. Thus, when the medical staff set criteria for medical audit of the care of patients at optimal outcomes, such items as indications for admission, length of stay and complications are also identified. This information is very easily obtained on a retrospective basis for the admission profile.

QUICK IDENTIFICATION

For example, in the admission of a patient with duodenal ulcer, the indications for admission might be the suspicion of bleeding, perforation or obstruction. It's very easy to review 100, 200 or 300 records retrospectively and to find out how many patients have been admitted for those reasons, how many patients have not, and who is responsible for the admissions that were not in the criteria. Therefore, physicians who are admitting inappropriately can be identified very quickly, and, if necessary, be placed on some type of concurrent monitoring system; the physicians who are admitting appropriately would be identified and not placed on any type of concurrent review system.

In addition, the length of stay can be determined on the basis of quality, not on the basis of a statistic modified by a particular region. Here's another example: An acute myocardial infarction patient should stay a minimum of 14 days. It is in this period of time that any complications can be identified and treated; in an uncomplicated myocardial infarction, the patient should probably be discharged within two or three or four days after this 14-day minimum period of observation. By setting these criteria and doing a retrospective review of prior discharges of acute M.I., the average length of time that patients are staying can be identified; those physicians who tend to keep their patients hospitalized longer without justified medical reasons can be identified, so that corrective action could be taken.

SETTING GROUND RULES

The other advantage of using medical audit as the hub of good utilization review is, again, that the medical staff has a responsibility for identifying the ground rules of admission and length-of-stay review. By starting with medical audit, the quality parameters are identified and the reasons for the acceptance by the medical staff are also identified, which makes utilization review easier to implement at a medical-staff level.

Part of the problem in involving physicians in UR has been that the pressure for cost containment has come from the third-party payers and the fiscal intermediaries, through the hospital administration. Since physicians are responsible for admitting and discharging patients, they contribute to possible inappropriate admissions and length of stay. The pressure from the administration to force physicians to comply with cost-containment measures only sets up a confrontation pattern. When you involve medical staff, through medical audit, in setting the parameters for quality of care--including admissions and length of stay--then it has both the authority and responsibility for good utilization review. The confrontation pattern between medical staffs and administrators is eliminated.

WHOLE PATTERNS SEEN

In addition, by making medical audit

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